

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

February 14, 2017

Angela Zizza, Manager
Valley Terrace
2820 Christian Street
White River Junction, VT 05001-9822

Dear Ms. Zizza:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on January 23, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief



PRINTED: 01/30/2017
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/23/2017
NAME OF PROVIDER OR SUPPLIER VALLEY TERRACE		STREET ADDRESS, CITY, STATE, ZIP CODE 2820 CHRISTIAN STREET WHITE RIVER JUNCTION, VT 05001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
R100	Initial Comments: An unannounced onsite complaint investigation was conducted by the Division of Licensing and Protection on 1/23/17. The findings include the following:	R100	
R165 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview the registered nurse failed to accept responsibility for the proper monitoring of staff performance for the administration of medications, for 5 sampled residents (Residents	R165	R165 SS=E 5.10.d The action taken to correct the above deficiency is outlined as follows: The Registered Nurse accepts all responsibility for the proper monitoring of staff performance for the administration of medications and has the following practices in place: All non-licensed medication technicians have full training on medication administration training before they can pass medications. The training includes four hours of classroom training along with a minimum of two full medication passes on all medication carts and periodic audits by the Health Services Director, along with required medication administration classes on a bi-yearly basis and an annual medication delegation exam. As of 1/24/17 the following training and monitoring is put into place for our licensed nursing staff: Additional online Training courses on Medication Administration have been added for our licensed nursing staff. Monthly and random audits will take place for all designated staff, licensed and non-licensed, for observation that medication administration is completed correctly and in compliance with state rules and regulations. (Continued)

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

(X6) DATE

PRJH11

If continuation sheet 1 of 3

R165 - POC accepted 2/13/17 M. Bertrand R. J. pm

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R165	Continued From page 1 #1, #2, #3, #4 and #5). The findings include the following: 1. Based on observation at approximately 8:41 AM, Resident #1 was found sitting in the dining room eating breakfast with one (1) pill in a souffle cup on the table. There was no nurse or medication technician present and there was another resident present at the table. The resident has physician orders for a total of ten (10) medications for the 8 AM medication pass. 2. Based on observation at approximately 8:41 AM, Resident #2 was found sitting in the dining room eating breakfast with four (4) pills in a souffle cup on the table. There was no nurse or medication technician present and there was another resident present at the table. The resident has physician orders for a total of four (4) medications for the 8 AM medication pass. 3. Based on observation at approximately 8:41 AM, Resident #3 was found sitting in the dining room eating breakfast with four (4) pills in a souffle cup on the table. There was no nurse or medication technician present and there was another resident present at the table. The resident has physician orders for a total of twelve (12) medications for the 8 AM medication pass. 4. Based on observation at approximately 8:41 AM, Resident #4 was found sitting in the dining room eating breakfast with four (4) pills in a souffle cup on the table. There was no nurse or medication technician present and there was another resident present at the table. The resident has physician orders for a total of six (6) medications for the 8 AM medication pass. 5. Based on observation at approximately 8:41	R165	The proper administration of medication review took place on 1/23/17 with the LPN who failed to monitor resident #1, #2, #3, #4 and #5 while taking their medications. The LPN was well aware that her current practice of medication administration was done improperly. The LPN also confirmed that on December 2, 2016 she read and signed the Medication Administration memorandum signed off by all designated staff who administer medications (please see attached memo). The results of these audits will be reported to the Quality Assurance committee on a quarterly basis.		

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R165	Continued From page 2 AM, Resident #5 was found sitting in the dining room eating breakfast with five-six (5-6) pills in a souffle cup on the table. There was no nurse or medication technician present. The resident has physician orders for a total of eight (8) medications for the 8 AM medication pass. Confirmation was made by the Licensed Practical Nurse (LPN) that she did leave the medications at the breakfast table for the residents to self administer as she delivered medications to other residents who were eating breakfast in their rooms. None of the five (5) residents have been approved to self administer oral medications. Per facility memorandum issued to all Medication Technicians and LPN's dated 12/2/16, identifies ["If the resident tells you to leave the medication and they will take it later. Politely inform them due to VT regulations, you cannot do that. You will gladly take them back to the cart until the resident calls for/or are ready for meds."]. This memorandum was signed by the LPN who confirmed that medications were left at the table.	R165		

December 2, 2016

TO: LPN's, RN's, and Medication Delegates

Proper medication management is one of the major issues in assisted living.

Medications are essential for the care of our residents. When used appropriately, medications are effective treatments for acute and chronic conditions. In fact, medications can dramatically improve a resident quality of life. On the flip side, if medications are not taken as ordered, there can be serious consequences.

OUR RESIDENTS RELY ON YOU FOR ACCURATE ADMINISTRATION:

When administering medications, we all need to ensure:

- Right Resident
- Right route
- Right time
- Right dose
- Right medication
- Right documentation

Even if a resident is capable of taking meds out of container handed to them by staff and can take medication without physical assistance. You are responsible to ensure **ALL MEDICATION IS TAKEN IN FRONT OF YOU** and not left with the resident.

If the resident tells you to leave the medication and they will take it later. Politely inform them due to VT regulations, you cannot do that. You will gladly take them back to the cart until the resident calls for/ or are ready for meds.

Please be aware that we will continue to follow up on resident/family valid concerns. We will also do random med pass monitoring in the near future.

I know how hard you all work and I appreciate your dedication. Residents care and safety are my first concern and will continue to be.

Sarah Vaughan-France
Health Services Director